Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:
VONO
PO BOX 15640
FORT WORTH TX 76119

Respondent Name:
BRITISH AMERICAN INSURANCE CO

MFDR Tracking Number:
M4-04-3998-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
Box Number 19

MDR Date Received:
NOVEMBER 26, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed issue is that the Carrier has not made full payment and reduced the payment stating 'M – reimbursement amount based on U&C allowance'. We resubmitted the claim to the Carrier requesting additional payment. The Carrier denied the request for additional payment stating the same. The expected out come of this issue is that we feel the claims should be paid. In accordance with DME Ground rules Section IX c states invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier or if no pre-negotiated amount, the fair and reasonable rate. We have billed the Carrier our usual and customary rate and have provided the Carrier with examples of audit sheets and/or copies of checks where other carriers in this area have established our fees as fair and reasonable amounts at the Commission has not established a MAR for this procedure."

Amount in Dispute: $92.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Medical Fee Guidelines require the provider to bill its usual and customary fee. However, the guidelines do not anticipate that the provider will be paid its usual and customary fee, unless it is less than the maximum allowable reimbursement under the guideline. 28 TEX. ADMIN. Code § 134.201, GR VI…Therefore, the fact that this provider billed its usual and customary fee, which is not in dispute, or was paid at that rate by payors in other systems is irrelevant. The statue only requires that workers' compensation insurers do not pay more than other payors. There is no requirement that they pay at the same rate. There is no fee guideline addressing the MAR for this particular wound dressing and thus, the carrier has determined a usual and customary amount consistent with the industry or the market. In light of carrier's methodology, the provider must therefore prove that the reimbursement received is not fair and reasonable. The provider has not submitted documentation that the reimbursement received does not cover its costs and allow for a reasonable profit. The documentation submitted by provider is irrelevant, as it represents payment by payors outside the workers' compensation context; therefore, it only establishes that the provider has billed is usual and customary charge, which is not in dispute. Because the provider has failed to prove

that reimbursement received is not fair and reasonable, the provider is not entitled to further reimbursement.

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2003	HCPCS Code E1399 – Wound Dressing – Covaderm 4 x 10 #13 and Tegaderm 4 x 10 #13	$92.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on November 26, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 2, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 11, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 19, 2003 and October 6, 2003
   - 500 – Reimbursement amount based on U&C allowance.
   - M – No MAR
   - 510 – Payment Determined.
   - O – Denial after reconsideration.

Issues

1. Did the requestor submit the request for medical fee dispute resolution timely and in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor support fair and reasonable reimbursement in accordance with 28 Texas Administrative Code §134.202(c)(6)?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor has met the requirements of 28 Texas Administrative Code §133.307(d) and (e).
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October 19, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.